June 28, 2002

SECOND REVISION

Re: Medical Dispute Resolution
MDR #: M2-02-0647-01
TWCC File #:
Injured Employee
DOI: SS#:
IRO Certificate No.: I RO 5055

Dear:

THIS SECOND REVISION TO THIS LETTER, ALONG WITH THE FIRST REVISION OF THE MEDICAL CASE REVIEW is presented to more clearly address the reviewer's intentions as to the number of visits in a chronic pain management program were determined to be medically necessary. This revision reflects no change in the reviewer's initial report, only a clarification.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Physical Medicine and Rehabilitation.

THE PHYSICIAN REVIEWER OF THIS CASE DISAGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER. THE REVIEWER IS OF THE OPINION THAT A CHRONIC PAIN MANAGEMENT PROGRAM BEGINNING WITH THIRTY (30) VISITS IS MEDICALLY NECESSARY.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of July, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0647-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of 30 visits for chronic pain management.
2. Correspondence.
3. Emergency room documentation.
4. History and physical and progress notes for 2002, 2001, and 2000.
5. Chiropractic progress notes.
6. Work hardening progress notes.
7. Operative reports.
8. Functional capacity evaluations.
9. Nerve conduction evaluations.
10. Radiology reports.

B. SUMMARY OF EVENTS:

This patient is a 21-year-old male who sustained an injury on ___ when he fell, hitting the right side of his face, right shoulder, right clavicle, and lower back. He apparently also had loss of consciousness during the injury. He has undergone extensive treatment for this, and a request was made for him to enter a chronic pain management program. That request was denied because the physician advisor stated there had never been any objective evidence of significant pathology related to this on-the-job injury, and there was no medical evidence of psychological problems impacting the patient's clinical course. It was felt that the patient had excessive treatment for minor soft tissue injury and was not a valid candidate for a chronic pain management program.

C. OPINION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE. I AM OF THE OPINION THAT THE OVERALL

INJURIES AND SITUATION WOULD BE APPROPRIATELY TREATED IN A CHRONIC PAIN MANAGEMENT PROGRAM BEGINNING WITH THIRTY (30) VISITS.

The reason for my disagreement is based on the evidence that I have reviewed in this chart and criteria for admission to a chronic pain management program.

Basically, the patient does demonstrate significant pathology as presented by the evidence in this chart. He has exhibited pain behavior and functional limitations that have disrupted his treatment, and while he has had excessive treatment for his minor soft tissue injuries, I think this does make him a candidate for a pain management program. I think the overall injuries and situation could be better treated and the length of treatment could be shortened with this patient in a chronic pain management program.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 2 July 2002